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Nos. 02-1845, 03-83

In the Supreme Court of the United States

AETNA HEALTH INC. et al., *Petitioners,*

v.

JUAN DAVILA, *Respondent.*

CIGNA HEALTHCARE OF TEXAS, *Petitioner,*

v.

RUBY R. CALAD, *Respondent.*

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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BRIEF OF *AMICI CURIAE* AMERICAN MEDICAL ASSOCIATION, TEXAS MEDICAL ASSOCIATION AND AMERICAN PSYCHIATRIC ASSOCIATION IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICI CURIAE*

With the consent of the parties, reflected in letters on file with the Clerk of the Court, the American Medical Association ("AMA"), Texas Medical Association ("TMA") and American Psychiatric Association ("APA") submit this brief as *amici curiae* in support of Respondents, Calad and Davila, pursuant to Rule 37 of this Court.[1]

The AMA, the largest nonprofit association of physicians and medical students in the United States, was founded in 1847 to promote the science and art of medicine and the betterment of public health. These remain its purposes today. It sponsors a vast array of educational, scientific, and public health programs. The AMA engages in advocacy on behalf of physicians and the patients they serve, including efforts to bring quality to managed care.

The TMA is a private, voluntary, nonprofit association of Texas physicians and medical students. The TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. Today, its maxim continues in the same direction: "Physicians Caring for Texans." Its more than 39,000 members practice in all fields of medical specialization.

The APA, with more than 40,000 members, is the nation's leading organization of physicians specializing in psychiatry. The APA has participated as *amicus* in many cases in this Court, including prior ERISA cases.

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[1] Pursuant to Rule 37.6 of the Rules of this Court, *amici* state that no counsel for a party authored this brief in whole or in part, and that no person or entity other than *amici* and their counsel made any monetary contribution to the preparation or submission of this brief. Pursuant to Rule 37.3 of the Rules of this Court, the parties have consented to the filing of this brief, and the consent letters have been filed with the Clerk of the Court.

In the present cases, *amici* are concerned that the result sought by Petitioner HMOs would insulate HMOs who make medical treatment decisions for patients who are participants and beneficiaries in ERISA group health plans from accountability for those decisions. Without such accountability, those patients will be more at risk of treatment decisions made for reasons other than what is best for the patient, and the quality of their medical care will be lessened.

This result can be avoided by focusing on the nature of Calad's and Davila's claims. Unlike the claims at issue in this Court's prior complete preemption decisions, Calad and Davila do not seek payment or reimbursement from an ERISA plan. Rather, they are patients suing HMOs who made medical treatment decisions; they allege that these treatment decisions caused them injury. This Court has never had to consider whether ERISA complete preemption would extend to such a suit. As *amici* will demonstrate, reference to this Court's complete preemption decisions under the Labor Management Relations Act ("LMRA") provides a means to resolve these issues. This resolution supports the result reached by the Court of Appeals for the Fifth Circuit and is consistent with the Court's prior complete preemption holdings under ERISA and the LMRA.

SUMMARY OF ARGUMENT

Respondents Calad and Davila were participants in group health plans sponsored by their respective employers. Each employer's plan was an "employee welfare benefit plan" subject to the Employee Retirement Income Security Act of 1974 (an "ERISA plan"). Each employer entered into a contract with a health maintenance organization ("HMO") to utilize a package of the HMO's services to provide benefits to the plan's participants.

Petitioners are the HMOs utilized by the ERISA plans to make medical benefits available to their participants and beneficiaries. Calad and Davila each sought diagnosis or treatment for a medical condition and, doing so, became a patient. The treating physician for each patient determined a course of treatment that was appropriate for the patient (extended hospitalization for Calad and a particular drug for Davila). Each HMO made a medical decision not to provide the treatment recommended by the treating physician, so each patient had a different course of treatment than prescribed by the treating physician (discharge for Calad and a different drug for Davila). Each patient alleged that his or her medical condition worsened because of the HMO's treatment decision.

Calad and Davila filed suit in State court against their respective HMOs, invoking the Texas Health Care Liability Act ("THCLA"), which provides that "[a] health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care." Their suits were removed to Federal court, but remanded by the Fifth Circuit.

The HMOs ask this Court to reverse the Fifth Circuit's holding that these suits may proceed in State court. The HMOs argue that these patients' claims are barred by the "complete preemption" exception to the "well-pleaded complaint doctrine," which this Court has recognized under the Employee Retirement Income Security Act of 1974 ("ERISA"). The HMOs are not seeking mere application of the Court's prior ERISA complete preemption holdings. They seek to extend those holdings to deny any patient who is a participant in an ERISA plan the right to hold an HMO accountable for a treatment decision. The result that

the HMOs seek is beyond the scope of the complete preemption doctrine.

Amici support the holding of the Fifth Circuit and urge the Court to affirm it. They believe that expansion of ERISA preemption as advocated by the HMOs is inconsistent with the Court's preemption jurisprudence and would have the effect of depriving patients who are also ERISA plan participants of State law protections, solely because they are ERISA plan participants.

The nature of Calad's and Davila's claims is critical to analysis of the complete preemption issue. Once a person seeks medical diagnosis or treatment, that person is a patient. As a patient, that person is entitled to State law rights and protections available to patients.

The HMOs try to characterize Calad's and Davila's claims as ordinary "claims for plan benefits." They refuse to acknowledge the fundamental difference of these claims from those held subject to ERISA complete preemption in prior decisions of this Court. The HMOs deny Calad's and Davila's rights as patients, as if ERISA participant status strips them of those rights. Calad and Davila did not seek anything from an ERISA plan that could be provided under ERISA's remedial scheme. They were injured patients, alleging that the HMOs made treatment decisions that violated Texas law standards for such decisions. This has nothing to do with any payment or reimbursement from an ERISA plan, or relief available under ERISA's remedial scheme.

Prior holdings of this Court dealing with ERISA complete preemption do not address claims involving medical treatment decisions. Instead, those cases involved State law suits alleging improper processing of disability benefit claims, or a wrongful discharge claim based on termination to avoid paying pension benefits. They involved claims based on *participant* status. Here, the HMOs' decisions

affected Calad and Davila *as patients*: Calad was discharged from the hospital; Davila received a different drug than his doctor prescribed.

This Court has repeatedly cautioned against expansive Federal preemption of State law. In recent terms, the Court has, in the context of ERISA's statutory preemption provision, discussed a presumption against preemption of the State's exercise of its "traditional police powers" and appeared skeptical of Congressional intent to federalize medical negligence law through ERISA. The bounds of ERISA complete preemption doctrine can best be determined by referring to cases construing the bounds of that doctrine vis-à-vis the LMRA, an act whose preemptive effect has served as the "model" for the Court's ERISA preemption analysis.

LMRA complete preemption jurisprudence has always recognized limits on such preemption. Under LMRA § 301, State law claims that are founded on rights or duties established by a collective bargaining agreement, or that substantially depend on the interpretation or analysis of that agreement, are preempted. However, State law claims are not preempted if the rights protected by the State law exist independently of the labor agreement, and the State law claim can be resolved without interpreting the labor agreement.

Applying these principles here, the complete preemption rule established by the Court's prior decisions should be clarified so that State law claims are not preempted if a State law claim: (1) does not seek to recover benefits, enforce rights or clarify rights to future benefits under the terms of an ERISA plan, or to enforce any substantive provision of ERISA; and (2) is independent of and can be adjudicated without analysis or interpretation of the ERISA plan. Applied to the present cases, the rule *Amici* suggest would confirm that the remand of Calad's and Davila's suits to State court was appropriate.

This result is appropriate and correct because it provides a symmetrical application of the complete preemption exception under ERISA and the LMRA, honors the Court's traditional restraint in the preemption of State police powers, and provides a clear rule for application by the lower Federal courts. It does not preclude any arguments that the State law is preempted under ERISA § 514, as these may be raised, along with any other defenses, on remand.

ARGUMENT

I. Calad's and Davila's Claims under State Law Are Not Claims for ERISA Plan Benefits.

Respondent Ruby Calad, the spouse of an employee of The Ryland Group-Ryland Homes, was covered under a group health plan established and maintained by Ryland. Calad Compl. ¶ 17. Respondent Juan Davila, an employee of Monitronics, was covered under a group health plan established and maintained by Monitronics. Davila Compl. ¶ 11.

Under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, each Respondent's employer's group health plan is an "employee welfare benefit plan" subject to ERISA (an "ERISA plan"). 29 U.S.C. §§ 1002(1), 1003(a). Respondent Calad is a "beneficiary" under ERISA and Respondent Davila is a "participant."[2] Calad's employer utilized an HMO arrangement offered by Cigna to provide medical benefits to participants and beneficiaries of its ERISA plan, and Davila's

[2] 29 U.S.C. §§ 1002(8), 1002(7). There is no difference between the terms "participant" and "beneficiary" for purposes of this analysis, so Calad and Davila are both described hereinafter as "participants" in their respective ERISA plans.

employer utilized an HMO arrangement offered by Aetna for the same purpose.

In 1999, Calad had a hysterectomy with rectal, bladder, and vaginal repair. Although the physician performing the surgery recommended a longer stay, Cigna's hospital discharge nurse decided that a one-day hospital stay was sufficient. Calad suffered complications that she attributes to her early release, received emergency room care and continued to suffer from these complications. *Roark v. Humana, Inc.*, 307 F.3d 298, 302 (5th Cir. 2002) ("*Roark*"); Calad Compl. ¶¶ 3-4.

Davila is a post-polio patient who suffers from diabetes and arthritis. In 2000, his primary care physician prescribed Vioxx for Davila's arthritis pain. Aetna required Davila to try two alternative drugs it considered appropriate for pain; only if he suffered a detrimental reaction to the medications or failed to improve could he obtain Vioxx. The first drug prescribed by Aetna was Naprosyn. After three weeks on it, Davila was rushed to the emergency room suffering from bleeding ulcers, which caused a near heart attack. He received seven units of blood and was in critical care for five days. As a result, he cannot take any pain medication that would be absorbed through the stomach. *Roark*, 307 F.3d at 303. Davila Compl. ¶¶ 12-15.

Each Respondent sued the respective HMO under the Texas Health Care Liability Act ("THCLA"), Tex. Civ. Prac. & Rem. Code § 88.001 *et seq*. (Vernon's 2003). The THCLA provides that "[a] health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care." Tex. Civ. Prac. & Rem. Code § 88.002(a). "Health care

treatment decision" is defined as "a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees." Tex. Civ. Prac. & Rem. Code § 88.001(5). "Ordinary care" is defined as "that degree of care that a health insurance carrier, health maintenance organization, or managed care entity of ordinary prudence would use under the same or similar circumstances [and in] the case of a person who is an employee, agent, ostensible agent, or representative of a health insurance carrier, health maintenance organization, or managed care entity, 'ordinary care' means that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as such person would use in the same or similar circumstances." Tex. Civ. Prac. & Rem. Code § 88.001(10).

Calad's suit alleged that Cigna had provided medical services to her and, in doing so, violated the THCLA. Davila's suit alleged that Aetna influenced, controlled, participated in or made health care treatment decisions and, in doing so, violated the THCLA. Each sought relief for lost earnings, pecuniary loss, physical pain and mental anguish, and specifically disclaimed "reimbursement for treatment, medical procedures, or hospitalization" and "recover[y] for denial of any benefits." Calad Compl. ¶¶ 29, 33-34; Davila Compl. ¶¶ 17-24. When the HMOs removed the cases to Federal court, they were only at the pleading stage, so no facts have been adduced.

At the time they sought medical diagnosis or care, Calad and Davila were participants in ERISA plans. Completely independent of ERISA, though, when a participant seeks and receives medical diagnosis or care, that person has another status: that of a patient. As a patient, a person has relationships with those who provide medical care or

diagnosis. The patient is protected in these relationships. Sources of this protection include self-regulation by professional associations such as *amici*, and the accountability under State law of those who provide medical care or diagnosis.

When a participant becomes a patient, ERISA continues to regulate the "participant" relationship, but the new "patient" relationship is regulated from other sources. ERISA does not protect patients from negligent diagnosis or treatment,[3] but nothing in ERISA or its legislative history suggests that participants who become patients are not to be protected from negligent diagnosis or treatment.

> [N]othing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern. . . .

N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 661 (1995) (citations omitted) ("*Travelers*").

> We find nothing in the legislative history suggesting that [ERISA] § 502 was intended as a part of a federal scheme to control the quality of the benefits received by plan participants.

Dukes v. U.S. Healthcare, Inc., 57 F.3d 350, 357 (3rd Cir. 1995).

The rights of patients under State law are separate and distinct from the rights of ERISA plan participants under ERISA. The THCLA is a statute that regulates the relationship between patients and those who make health care treatment decisions for them.

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[3] *Cf. Thompson v. GenCare Health Sys., Inc.*, 49 F. Supp. 2d 1145, 1147 (E.D. Mo. 1999), *aff'd*, 202 F.3d 1072 (8th Cir. 2000).

Calad's treating physician prescribed a course of treatment that included more time in the hospital. Cigna determined that Calad was not hemorrhaging or exhibiting a fever or high blood pressure and would have to leave the hospital or pay approximately $1,500 per day to stay. As a result, Calad's course of treatment changed: she was discharged from the hospital.

Davila's treating physician prescribed a course of treatment that included the drug Vioxx. A formulary prepared by Aetna required Davila to try two other drugs in a "step program" before he could receive Vioxx, unless he could demonstrate "contraindication, intolerance, [or] allergy" to the other drugs. Out of fifteen possible pain-relieving drugs in its formulary, Davila received a prescription for Naprosyn. Davila Compl. ¶¶ 13-15; Aetna Br. at 9. As a result, Davila's course of treatment changed: he received a prescription for Naprosyn instead of Vioxx.

The actions of each HMO satisfy the THCLA's definition of a "health care treatment decision," that is, "a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees." Tex. Civ. Prac. & Rem. Code § 88.002(a)(5). Calad and Davila each allege serious medical consequences as a result of the HMO health care treatment decisions.

Against common sense and the plain allegations in the Complaints, the HMOs disingenuously argue that they do not make health care treatment decisions. Aetna Br. at 6-7, 14-15, 26-27; Cigna Br. at 37. But there can be no question that each HMO made a decision involving discretionary consideration of medical factors which affected the quality of care or treatment received by Calad and Davila. Cigna's nurse (or someone who instructed the nurse) had to determine that Calad was not hemorrhaging,

feverish or exhibiting high blood pressure and that the absence of such symptoms justified denial of continued hospitalization. Someone at Aetna had to determine that Davila should take Naprosyn, out of fifteen permitted drugs, for his pain.[4] These decisions are "health care treatment decisions" within the THCLA definition and within any plain-meaning sense of those words.[5]

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[4] While Cigna and Aetna claim that they are not engaged in making medical decisions, each of these companies employ physicians and nurses as medical directors and engage in extensive "utilization review." On its web site at http://www.cigna.com/general/careers/featured (visited Jan. 20, 2004), Cigna provides the following job description for the position of a nurse to act as a Case Manager: "As a case manager with CIGNA HealthCare, you'll apply your professional skills and expertise in the assessment, planning, implementation, and coordination of necessary health care services for selected CIGNA members." At that same site, Cigna describes its nurse Patient Care Coordinator position as follows: "[Y]ou'll conduct daily concurrent reviews for all assigned admissions and participate in the care, *treatment* and discharge planning for members in an inpatient setting." (Emphasis added).

[5] The HMOs callously suggest that if they deny care, the patient should simply pay for it out-of-pocket and then seek reimbursement. As a practical matter, most people do not have the financial resources to do this; they go without care and suffer the consequences. This is well documented. *See, e.g.*, M.K. Wynia et al., *Do Physicians Not Offer Useful Services Because of Coverage Restrictions?*, Health Affairs, Jul.-Aug. 2003, at 190 (almost one in three physicians surveyed reported not offering useful but uncovered services to their patients, and the trend seems to be growing); R.G. Roetzheim et al., *Effects of Health Insurance and Race on Colorectal Cancer Treatments and Outcomes*, 90 Am. J. Pub. Health 1746 (2000) (patients with colorectal cancer who were uninsured or insured by Medicaid or commercial HMOs had higher mortality rates than patients with commercial fee-for-service insurance); *Insuring America's Health: Principles and*

(continued...)

Calad's and Davila's Complaints each set out all necessary elements of a claim against an HMO under the THCLA. They allege, particularly in Davila's claim against Aetna, that the HMO affirmatively provided medical care and was not a passive administrator. Nothing in either Complaint seeks to recover benefits due under the terms of the ERISA plan, to enforce rights under the terms of the ERISA plan, or to clarify rights to future benefits under the terms of the ERISA plan. Nothing in either Complaint seeks to enforce any substantive provision of ERISA. Their claims are the claims of injured patients seeking accountability for health care treatment decisions, not the claims of plan participants seeking remedies under ERISA. Such claims are not subject to ERISA complete preemption under this Court's prior holdings.

II. The Court's Previous ERISA Complete Preemption Decisions Do Not Address Claims Like Calad's and Davila's, Which Seek Neither Benefits under an ERISA Plan nor Enforcement of a Substantive Provision of ERISA.

The Court has dealt with the "complete preemption" exception under ERISA to the well-pleaded complaint doctrine in five cases. In *Franchise Tax Bd. of Cal. v.*

(...continued)
Recommendations, report, *available at* http://www.iom.edu/report, (visited Jan. 21, 2004) (underinsured and uninsured individuals are lower income and are less likely to pay out-of-pocket for services; instead, they go without care). *Amici* recognize that the beneficiary in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), did incur the expense of the HMO-denied treatment, but in order to do so, she withdrew all funds from her unemployed husband's IRA and charged her mother-in-law's and her own credit cards to their limits.

Construction Laborers Vacation Trust for S. Cal., 463 U.S. 1, 7-12 (1983) ("*Franchise Tax Board*"), the Court first considered whether "ERISA, like § 301 [of the Labor Management Relations Act of 1947 ("LMRA"), 29 U.S.C. § 141 *et seq.*], was meant to create a body of federal common law, and that 'any state court action which would require the interpretation or application of ERISA to a plan document "arises under" the laws of the United States.'" 463 U.S. at 24. Justice Brennan's opinion suggested such an extension of the LMRA doctrine to ERISA:

> ERISA contains provisions creating a series of express causes of action in favor of participants, beneficiaries, and fiduciaries of ERISA-covered plans, as well as the Secretary of Labor. § 502(a), 29 U.S.C. § 1132(a). It may be that, as with § 301 as interpreted in *Avco*, any state action *coming within the scope of § 502(a) of ERISA* would be removable to federal district court, even if an otherwise adequate state cause of action were pleaded without reference to federal law.

Id. (emphasis added).

However, the extension did not occur in *Franchise Tax Board* because "[n]either of appellant's claims in this case comes within the scope of one of ERISA's causes of action." *Id.* While the state law claims may have involved ERISA plans, they did not come within the scope of § 502(a)'s causes of action. In its subsequent decisions, the Court dealt with State law claims which did come within the scope of the § 502(a) causes of action.

In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) ("*Pilot Life*"), a participant challenged the way his claims for disability benefits under an ERISA plan were handled. He made no claim under ERISA, but sued under three State law causes of action, seeking various general, punitive and exemplary damages. *Pilot Life*, 481 U.S. at 43-44. The Court, in a unanimous opinion by Justice O'Connor, held

that the State law claims fell under ERISA's statutory preemption provision, § 514(a), and then went on to consider whether they were "saved" under the "saving clause" in § 514(a)(2). *Pilot Life*, 481 U.S. at 47-48. That analysis, though, "must be informed by the legislative intent concerning the civil enforcement provisions provided by ERISA 502(a), 29 U.S.C. § 1132(a)." *Id.* at 52. The Court continued:

> The Solicitor General, for the United States as *amicus curiae*, argues that Congress clearly expressed an intent that the civil enforcement provisions of ERISA 502(a) be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits, and that varying state causes of action for claims within the scope of 502(a) would pose an obstacle to the purposes and objectives of Congress . . . We agree.

Id. (emphasis added) (internal citations omitted). The Court reviewed ERISA legislative history:

> The Conference Report on ERISA describing the civil enforcement provisions of 502(a) says:
>
> > "Under the conference agreement, civil actions may be brought by a participant or beneficiary to recover benefits due under the plan, to clarify rights to receive future benefits under the plan, and for relief from breach of fiduciary responsibility. . . . [W]ith respect to suits to enforce benefit rights under the plan or to recover benefits under the plan which do not involve application of the title I provisions, they may be brought not only in U.S. district courts but also in State courts of competent jurisdiction. *All such actions in Federal or State courts are to be regarded as arising under the laws of the United States in similar fashion to those brought under section 301 of the Labor-Management Relations Act of 1947*." H.R.Conf.Rep. No. 93-1280, p. 327 (1974), U.S.Code Cong. & Admin.News 1974, pp. 4639, 5107.

Id. at 55 (italics in original) (underline emphasis added). The Court next discussed the scope of preemption under the LMRA:

> [T]he broad pre-emptive effect of § 301 was first analyzed in *Teamsters v. Lucas Flour Co.*, 369 U.S. 95 (1962). In *Lucas Flour* the Court found that "[t]he dimensions of § 301 require the conclusion that substantive principles of federal labor law must be paramount *in the area covered by the statute*." *Id.*, at 103.

Id. (emphasis added). The Court concluded:

> Congress' specific reference to § 301 of the LMRA to describe the civil enforcement scheme of ERISA makes clear its intention that all suits brought by beneficiaries or participants *asserting improper processing of claims under ERISA-regulated plans* be treated as federal questions governed by § 502(a).

Id. at 56 (emphasis added).

On the same day, the Court decided *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987) (*"Taylor"*). *Taylor* also involved a challenge to claims processing under an ERISA plan, but, unlike *Pilot Life*, was brought in State court. *Taylor*, 481 U.S. at 60-61. In another unanimous opinion by Justice O'Connor, the Court held that the State law contract and tort claims seeking benefits owed plus additional damages were preempted, citing *Pilot Life* and ERISA § 514(a). *Id.* at 62. It went on to consider whether the State law claims "were also displaced by ERISA's civil enforcement provision, § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), to the extent that complaints filed in state courts purporting to plead such state common law causes of action are removable to federal court under 28 U.S.C. § 1441(b)." *Id.* at 60. In deciding that they were, the Court observed that the State lawsuit, *"as a suit by a*

beneficiary to recover benefits from a covered plan . . . falls directly under § 502(a)(1)(B) of ERISA, which provides an exclusive federal cause of action for resolution of such disputes." *Id.* at 62-63 (emphasis added). Discussing the same legislative history relied upon in *Pilot Life*, Justice O'Connor described it as a "clear intention to make § 502(a)(1)(B) suits brought by participants or beneficiaries federal questions for the purposes of federal court jurisdiction in like manner as § 301 of the LMRA." *Id.* at 66 (emphasis added).

Under *Pilot Life* and *Taylor*, certain State law actions by participants and beneficiaries are removable to Federal court and are treated as Federal questions governed by § 502(a). The class of actions subject to this "complete preemption" is described in *Pilot Life* as "suits brought by beneficiaries or participants asserting improper processing of claims under ERISA-regulated plans," *Pilot Life*, 481 U.S. at 56, and in *Taylor* as "§ 502(a)(1)(B) suits brought by participants or beneficiaries" (*i.e.*, suits to recover benefits due under the terms of the ERISA plan, to enforce rights under the terms of the ERISA plan, or to clarify rights to future benefits under the terms of the ERISA plan). *Taylor*, 481 U.S. at 66.

Neither Complaint in the cases before the Court can be accurately characterized in those terms. The preempted class of cases is thus defined by the class of cases that may be brought under § 502(a), which is logical, as "[§ 502(a)] does not purport to reach every question relating to plans covered by ERISA." *Franchise Tax Board*, 463 U.S. at 25.

The Court next addressed these issues in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990) ("*Ingersoll-Rand*"). At issue there was a State wrongful discharge action alleging that the primary reason for firing the employee was "to deprive him of pension benefits under an ERISA

plan." *Ingersoll-Rand*, 498 U.S. at 136. The Court found that the suit was "explicitly preempted" under ERISA § 514(a), *id.* at 138-42, and then determined that the claim was "implicitly preempted," "because it conflict[ed] directly with an ERISA cause of action." *Id.* at 142. Specifically, the Court held: ERISA § 510 "protects plan participants from termination motivated by an employer's desire to prevent a pension from vesting;" ERISA § 502(a) is "the exclusive remedy for rights guaranteed under ERISA, including those provided by § 510;" *id.* at 143-44, and "the exclusive remedy provided by § 502(a) is precisely the kind of 'special featur[e]' that 'warrant[s] pre-emption' in this case." *Id.* at 144. The Court concluded:

> [T]he Texas cause of action purports to provide a remedy for the violation of a right expressly guaranteed by § 510 and exclusively enforced by § 502(a). Accordingly we hold that "[w]hen it is clear or may fairly be assumed that the activities which a State purports to regulate are protected" by § 510 of ERISA, "due regard for the federal enactment requires that state jurisdiction must yield."[6]

Id. at 145. Thus, for there to be "implicit preemption" of a State law claim under *Ingersoll-Rand*, the claim must be for violation of ERISA § 510 (or, it would seem, some other substantive provision of ERISA) which is "exclusively enforced" under § 502(a). The Complaints in the cases now before the Court cannot be characterized as making such a claim.

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[6] This language is drawn from footnote 8 of the Court's opinion in *Lingle v. Norge Div. of Magic Chef, Inc.*, 486 U.S. 399 (1988), an LMRA preemption case. In that footnote, the Court discussed Federal labor-law principles other than LMRA § 301 that may preempt State law. 486 U.S. at 408-09 & n.8.

Finally, complete preemption was discussed in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) ("*Moran*"). There, the Court held both that a State-mandated independent review of HMO "medical necessity" decisions was "saved" from § 514 preemption as insurance law, *Moran*, 536 U.S. at 365-75, and that the independent review procedure was not completely preempted either, because it "provides no new cause of action under state law and authorizes no new form of ultimate relief." It "does not enlarge the claim beyond the benefits available in any action brought under § [502(a)]," and functioned more like a "rule of decision" which would then be enforced in a § 502(a) suit. *Id.* at 379-80.

Moran's holding does not add to the types of claims completely preempted under *Pilot Life*, *Taylor*, and *Ingersoll-Rand*. Indeed, the Court declined "to turn dictum into holding by declaring that the state insurance regulation . . . is preempted." *Moran*, 536 U.S. at 377. Justice Souter noted that, after *Pilot Life*, "we have found only one other state law to 'conflict' with [§ 502(a)] in providing a prohibited alternative remedy." *Id.* at 379. That case, of course, was *Ingersoll-Rand*, and the discussion of that decision in *Moran* provides a useful summary of the Court's ERISA complete preemption holdings:

> [In *Ingersoll-Rand*] we had no trouble finding that Texas's tort of wrongful discharge, turning on an employer's motivation to avoid paying pension benefits, conflicted with ERISA enforcement; while state law duplicated the elements of a claim available under ERISA, it converted the remedy from an equitable one under [§ 502(a)(3)] (available exclusively in federal district courts) into a legal one for money damages (available in a state tribunal). Thus, *Ingersoll-Rand* fit within the category of state laws *Pilot Life* had held to be incompatible with ERISA's enforcement scheme; the law provided a form of ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA.

Moran, 536 U.S. at 379.

Out of context, the last sentence just quoted from *Moran* might be read to suggest a broader holding in *Ingersoll-Rand* than was the case. Given the Court's focus in *Ingersoll-Rand* on the enforcement of § 510 through § 502(a), the statement "*Ingersoll-Rand* fit within the category of state laws *Pilot Life* had held to be incompatible with ERISA's enforcement scheme; the law provided a form of ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA" appears limited to judicial remedies provided by ERISA *for* violations of ERISA.

In summary, a State law claim will be completely preempted if it is a claim for benefits described in § 502(a)(1)(B), *see Pilot Life*, 481 U.S. at 57; *Taylor*, 481 U.S. at 62-63, or if it seeks to enforce a right protected by ERISA and enforced through § 502(a). *See Ingersoll-Rand*, 498 U.S. at 145. In *Pilot Life* and *Taylor*, plan participants were seeking disability benefits under State law, while ERISA § 502(a)(1)(B) provided a specific cause of action to seek such benefits. In *Ingersoll-Rand*, the former participant's State lawsuit was premised on the employer's desire not to pay pension benefits, while under ERISA § 510, enforced through § 502(a)(3), "the relief requested . . . is well within the power of federal courts to provide." *Ingersoll-Rand*, 498 U.S. at 145. In *Moran*, the State independent review mechanism was held to be ancillary to § 502(a)(1)(B) as the means to seek reimbursement for health care expenses incurred by the participant. *See Moran*, 536 U.S. at 380.

In each of the cases in which complete preemption was found, the challenged actions raised a question that could be specifically addressed under § 502(a): Were disability

benefits due to Dedeaux and Taylor under the terms of the plan? Was McClendon discharged for the purpose of interfering with the attainment of any right to which he might become entitled under the plan? Similarly, in *Moran*: could the State independent review procedure be used in determining whether reimbursement of her medical expenses was due to Moran under the terms of the plan?

By contrast, the questions raised by Calad and Davila are not addressed by ERISA: Was the decision that Calad did not have symptoms that required continued hospitalization made with the exercise of ordinary care? If not, was that failure the proximate cause of harm to her? Was the decision to prescribe Naprosyn for Davila's pain made with the exercise of ordinary care? If not, was that failure the proximate cause of harm to him?

Here, the HMOs' actions affect Calad and Davila as patients; neither received the course of treatment prescribed by his or her treating physician. This implicates the protections which Texas has created in the THCLA for patients who are injured by health care treatment decisions. Calad and Davila assert claims under the THCLA against the HMOs that are separate, distinct and independent from ERISA's causes of action, like the claims in *Franchise Tax Board*, neither of which "[came] within the scope of one of ERISA's causes of action." 463 U.S. at 24-25. The question the Court must resolve is whether, under the complete preemption exception to the well-pleaded complaint doctrine, they can bring these claims in State court (subject, of course, to any defenses, including ERISA § 514 defenses, raised by the HMOs).

The holdings in the Court's ERISA complete preemption cases do not answer this question. Calad's and Davila's State lawsuits do not seek payments, reimbursement or any other benefit from an ERISA plan. *Cf. Pilot Life*, 481 U.S. at 57; *Taylor*, 481 U.S. at 62-63. They do not seek

to enforce any statutory right under ERISA through § 502(a)(3). *Cf. Ingersoll-Rand*, 498 U.S. at 145. If we study the basis for the holdings articulated in these three opinions, we see that in each case the Court described complete preemption, with reference to ERISA's legislative history, e.g., as "modeled after § 301 of the LMRA." *Pilot Life*, 481 U.S. at 54; *see also Taylor*, 481 U.S. at 65-67 ("in like manner as § 301 of the LMRA"), and *Ingersoll-Rand*, 498 U.S. at 144-45 ("the parallel between § 502(a) and § 301 of the LMRA"). Therefore, any consideration of the scope of ERISA § 502 complete preemption should be made with reference to the scope of LMRA § 301 complete preemption.

III. This Court's LMRA § 301 Complete Preemption Jurisprudence Recognizes Limits on Preemption and Provides a Related Body of Precedent, Applicable to the Cases Before the Court.

The Court adopted the LMRA § 301 complete preemption exception to the well-pleaded complaint rule in *Avco Corp. v. Aero Lodge No. 735*, 390 U.S. 557 (1968), it then explained the scope of LMRA § 301 complete preemption in a series of cases beginning in 1985. The development of ERISA § 502 complete preemption occurred simultaneously with, and was intertwined with, these LMRA decisions.[7] This Court has heard more cases, presenting more issues, in connection with LMRA complete preemption than ERISA complete preemption. Heeding the Congressional intent that cases under ERISA § 502 "be regarded . . . in

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[7] *See Franchise Tax Board* (1983) (ERISA); *Lueck* (1985) (LMRA); *Pilot Life* (1987) (ERISA); *Taylor* (1987) (ERISA); *Hechler* (1987) (LMRA); *Caterpillar* (1987) (LMRA); *Lingle* (1988) (LMRA); *Rawson* (1990) (LMRA); *Ingersoll-Rand* (1990) (ERISA); *Livadas* (1994) (LMRA).

similar fashion" to those brought under LMRA § 301, we can turn to existing precedent of this Court under § 301 for guidance in the present cases.

LMRA § 301 complete preemption is based on the Supremacy Clause of Article VI of the Constitution. *See Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 208 (1985) ("*Lueck*"). Because Congress has never exercised the authority to occupy the entire field of labor legislation, the question of whether a State action is preempted is limited to Congressional intent. *Id.*[8] State law claims that are founded on rights or duties established by a collective bargaining agreement, or that substantially depend on the interpretation or analysis of a collective bargaining agreement, are preempted. *Lueck*, 471 U.S. at 213 (State tort of bad faith handling of disability benefit payments due under a labor contract is preempted by LMRA § 301; claim is "inextricably intertwined" with, and substantially dependent upon, interpretation of the labor contract);[9] *International Brotherhood of Electrical Workers, AFL-CIO, et al. v. Hechler*, 481 U.S. 851 (1987) (negligence claim against union preempted because claim depended on whether the union had contractually assumed a duty of care for its members, requiring the interpretation of the labor contract); *United Steelworkers of America, AFL-CIO v. Rawson*, 495 U.S. 362 (1990) (tort claim preempted where duty allegedly assumed by union did not exist outside of collective bargaining agreement).

[8] Accordingly, LMRA § 301 complete preemption is conflict preemption, not express or implied preemption. *See* K. Jordan, *The Complete Preemption Dilemma: A Legal Process Perspective*, 31 Wake Forest L. Rev. 927, 955 (1996). *See also Lueck*, 471 U.S. at 208-09. *See generally Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363, 372-73 (2000); *Hines v. Davidowitz*, 312 U.S. 52, 70 (1941).

[9] In addition, the Court found that if the claim at issue were not preempted, an employee would have the option of bypassing the grievance procedures and going to State court, thereby compromising the Federal right of the parties to choose arbitration as the means to resolve labor contract disputes. *Lueck*, 471 U.S. at 219-20; *see also Lingle*, 486 U.S. at 411 (same).

Complete preemption under § 301 of the LMRA addresses the need for a unified body of Federal law to govern the interpretation and enforcement of collective bargaining agreements. *Textile Workers Union of America v. Lincoln Mills of Alabama*, 353 U.S. 448, 456-57 (1957). Moreover, Congress intended, through § 301, to specifically enforce promises to arbitrate grievance disputes under collective bargaining agreements. *Id.* at 451; *see also Local 174, Teamsters v. Lucas Flour Co.*, 369 U.S. 95, 105 (1962) ("the basic policy of national labor legislation [is] to promote the arbitral process as a substitute for economic warfare"); *Avco*, 390 U.S. at 559 (§ 301 of the LMRA was "fashioned by Congress to place sanctions behind agreements to arbitrate grievance disputes").

Outside the scope of the rights and duties established by the collective bargaining agreement and interpretation of the collective bargaining agreement, the rationale for preemption is not present.

> But even under § 301 we have never intimated that any action merely relating to a contract within the coverage of § 301 arises exclusively under that section. For instance, a state battery suit growing out of a violent strike would not arise under § 301 simply because the strike may have been a violation of an employer-union contract.

Franchise Tax Board, 463 U.S. at 25 & n.28 (citing *U.A.W. v. Russell*, 356 U.S. 634, 640-42 (1958)).

> [W]hile this sensible "acorn" of § 301 pre-emption recognized in *Lucas Flour* has sprouted modestly in more recent decisions of this Court . . . it has not yet become, nor may it, a . . . "mighty oak."

Livadas v. Bradshaw, 512 U.S. 107, 122 (1994) (citations omitted).

This Court has held that State law claims are *not* preempted if (1) the rights that the State law protects exist independently of the labor agreement, and (2) the State law claim can be resolved without interpreting the labor agreement. *Lueck*, 471 U.S. at 212 ("it would be inconsistent with congressional intent under [§ 301] to preempt state rules that proscribe conduct, or establish rights and obligations, independent of a labor contract").

In *Lingle v. Norge Division of Magic Chef, Inc.*, an employee's State court claim for retaliatory discharge for exercising rights under the Illinois Workers' Compensation Act was held not preempted by LMRA § 301, despite the fact that the collective bargaining agreement protected the employee from termination without "just cause." *Lingle*, 486 U.S. at 408-10. The Court reasoned that the plaintiff's claim rested on "purely factual questions pertain[ing] to the conduct of the employee and the conduct and motivation of the employer." *Id.* at 407. Because the elements of the State law retaliatory discharge claim did not turn on the meaning of any provision of the collective bargaining agreement, the claim was not preempted. *Id.* Even if resolution of the State law claim and a claim pursuant to the collective bargaining agreement would require addressing "precisely the same set of facts," there is no preemption as long as the State claim can be resolved without interpreting the agreement. *Id.* at 409-10; *see also Livadas*, 512 U.S. at 123-24 (the mere fact that a collective bargaining agreement would be consulted in the course of the State law litigation did not give rise to preemption).

Similarly, in *Caterpillar Inc. v. Williams*, employees brought claims that Caterpillar discharged them in violation of alleged individual employment agreements. 482 U.S. 386 (1987). Caterpillar argued that because the

employees were covered by a collective bargaining agreement at the time of their termination, their breach of contract claims were preempted by LMRA § 301. The Court disagreed, reasoning that while the employees *could have* brought suit under § 301, and had substantial rights under the collective bargaining agreement as bargaining unit members at the time of their termination, this did not give rise to preemption. *Id.* at 394-95. The Court found that their complaint did not "substantially depend" upon interpretation of the collective bargaining agreement. *Id.* at 394-95.

Most recently, in *Livadas*, the Court held that a State statute requiring employers to pay immediately all wages due to discharged employees, as applied to employees governed by a collective bargaining agreement, was not preempted by LMRA § 301, stating: "§ 301 cannot be read broadly to preempt nonnegotiable rights conferred on individual employees as a matter of state law" and "it is the legal character of a claim, as 'independent' of rights under the collective bargaining agreement . . . that decides whether a state cause of action may go forward." *Livadas*, 525 U.S. at 123-24 (internal citation omitted).[10]

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[10] Following this Court's precedent, numerous Federal circuit courts have refused to find LMRA § 301 complete preemption where the State law claims could be resolved independently of the collective bargaining agreement. *See, e.g.*, *Northwestern Ohio Administrators, Inc. v. Walcher & Fox, Inc.*, 270 F.3d 1018 (6th Cir. 2001) (claim that union fraudulently induced employer to sign project agreements not preempted); *Sprewell v. Golden State Warriors*, 266 F.3d 979 (9th Cir. 2001) (claims for intentional interference with contract and business relations not preempted to the extent based on California law and not collective bargaining agreement); *Pennsylvania Nurses Assoc. v. Pennsylvania State Education Assoc.*, 90 F.3d 797 (3d Cir. 1996) (breach of fiduciary duty and fraud claims were not preempted by § 301); *Trans Penn*

(continued...)

Significantly, in *Caterpillar*, the Court recognized that an "independent" State law claim could not be recharacterized as a Federal § 301 claim in order to give rise to preemption, merely because plaintiffs *could have* brought suit under § 301. *Caterpillar*, 482 U.S. at 394-95.

> Caterpillar impermissibly attempts to create the prerequisites to removal by ignoring the set of facts (*i.e.*, the individual employment contracts) presented by respondents, along with their legal characterization of those facts, and arguing that there are different facts respondents might have alleged that would have constituted a federal claim. In sum, Caterpillar does not seek to point out that the contract relied upon by respondents is in fact a collective agreement; rather it attempts to justify removal on the basis of facts not alleged in the complaint. The "artful pleading" doctrine cannot be invoked in such circumstances.

Id. at 396-97.

These well-established principles under LMRA § 301, allowing bargaining unit members to assert claims that arise independent of that status. Thus, the LMRA, the statute that Congress and this Court have identified as the "model" for ERISA § 502, instruct that the claims at issue are not subject to complete preemption under ERISA § 502.

Calad's and Davila's State law rights as patients are independent of the ERISA plan. When an HMO makes a health care treatment decision subject to the THCLA, that act has legal consequences separate and distinct from ERISA's remedial scheme.

(...continued)
Wax Corp. v. McCandless, 50 F.3d 217 (3d Cir. 1995) (claims for breach of individual employment agreements, fraud, and intentional infliction of emotional distress were not subject to § 301 preemption).

Each element of Calad's and Davila's THCLA claims can be determined without analysis or interpretation of the ERISA plans. First, there must be a "health care treatment decision," as defined in the statute. That decision must be made by a "health insurance carrier, health maintenance organization, or other managed care entity for a health care plan" (each term as defined in the statute) or an employee, agent, ostensible agent or certain representative (terms whose meanings can be determined under general law principles). There must be a failure to exercise "ordinary care" (as defined in the statute) in making the decision, and that failure must be the "proximate cause" of "harm" to the insured or enrollee. This is the stuff of ordinary tort litigation, overlaid with some specific statutory definitions, not analysis or interpretation of an ERISA plan.

The rights of Calad and Davila, as patients, under the THCLA can be preserved with a rule that interprets the scope of ERISA § 502 complete preemption to cover claims (1) to recover benefits, enforce rights or clarify rights to future benefits under the terms of an ERISA plan, or enforce any substantive provision of ERISA; or (2) which are not independent of or cannot be resolved without analysis or interpretation of the ERISA plan. *See Lingle*, 486 U.S. at 408-10. *Amici* urge the Court to do so.

This result leaves the Court's prior ERISA § 502 complete preemption holdings undisturbed. The claims in *Pilot Life, Taylor* and *Ingersoll-Rand* are covered by part (1) of the rule proposed above, while *Moran* demonstrates that there is no complete preemption of a State law claim that does not provide a new cause of action described in part (1). *Franchise Tax Board* continues to remind us that the scope of § 502(a), and thus its preemptive effect, is limited. The Court's prior holdings would continue to be precedent with respect to State law claims that seek to recover benefits, enforce rights or clarify rights to future benefits under the terms of an ERISA plan, or enforce any

substantive provision of ERISA. Part (2) of the rule urged by *amici* today would provide the next step of ERISA § 502 complete preemption analysis. It derives directly from *Lueck* and subsequent LMRA § 301 complete preemption cases, substituting the ERISA plan for the collective bargaining agreement. (The plan is to ERISA § 502 as the collective bargaining agreement is to LMRA § 301.) *Amici* believe that such a holding is appropriate for several reasons.

First, it would honor the Court's repeated admonitions that preemption of State law is to be undertaken carefully and narrowly in cases like this which involve a State's exercise of its "traditional police powers" for the health and safety of its citizens. *See English v. General Elec. Co.*, 496 U.S. 72, 79 (1977); *Maurer v. Hamilton*, 309 U.S. 598, 614 (1940); *see also Hillsborough County v. Automated Med. Labs.*, 471 U.S. 707, 715 (1985).

Second, it would adhere to the ERISA legislative history that ERISA § 502 be construed similarly to LMRA § 301. LMRA § 301 complete preemption applies to claims that: (1) are founded on rights or duties established by a collective bargaining agreement and enforced under § 301; or (2) substantially depend on the interpretation or analysis of a collective bargaining agreement. ERISA § 502 complete preemption would apply to State law claims that: (1) seek to recover benefits, enforce rights or clarify rights to future benefits under the terms of an ERISA plan, or to enforce any substantive provision of ERISA; or (2) are not independent of or cannot be resolved without analysis or interpretation of an ERISA plan. The ERISA § 502(a) remedial scheme is preserved and kept exclusive for claims available under it, as the LMRA § 301 enforcement scheme is preserved and kept exclusive to enforce rights and duties under a collective bargaining contract. The interpretation of the ERISA plan, like the interpretation of the collective bargaining contract, is reserved as a matter of Federal law.

Such a holding would also be consistent with the Court's presumption against preemption, regardless of the source or type of preemption, expressed in *Travelers* with respect to State regulation of health care:

> Our past cases have recognized that the Supremacy Clause, U.S. Const., Art. VI, may entail pre-emption of state law either by express provision, by implication, or by a conflict between federal and state law. And yet, despite the variety of these opportunities for federal preeminence, we have never assumed lightly that Congress has derogated state regulation, but instead have addressed claims of pre-emption with the starting presumption that Congress does not intend to supplant state law. Indeed, in cases like this one, where federal law is said to bar state action in fields of traditional state regulation, we have worked on the "assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress."

Travelers, 514 U.S. at 654-55 (internal citations omitted).

In addition, it is also consistent with the Court's observation in *Pegram v. Herdrich*, 530 U.S. 211 (2000), that "we have seen enough to know that ERISA was not enacted . . . to federalize malpractice litigation in the name of fiduciary duty or for any other reason." *Pegram*, 530 U.S. at 236. For ERISA, which does not even mention health care treatment standards, to preempt the remedies of a patient for negligent diagnosis or treatment because that patient is also an ERISA participant is at odds with the purpose of a statute intended to be remedial, and protective of employees' rights.

Finally, such a holding will provide useful guidance for lower Federal courts, which often hear complete preemption challenges to State law negligence, wrongful death or similar claims against an HMO that failed to provide a

particular course of treatment to a patient who was an ERISA plan participant. The holdings in these cases often turn on whether the court finds the HMO's decision to involve the "quality" of benefits provided (no complete preemption) or the "quantity" of benefits sought (complete preemption). However, this test invites judicial hair-splitting, causing courts to reach conflicting results under similar facts.[11]

CONCLUSION

For the foregoing reasons, *amici* urge the Court to recognize that when a State, in the course of its regulation of matters of health and safety, provides a cause of action like that available to injured patients under the THCLA, that cause of action will not be denied to patients who are also ERISA plan participants, if the State law claim (1) does not seek to recover benefits, enforce rights or clarify rights to future benefits under the terms of an ERISA plan, or to enforce any substantive provision of ERISA, and (2) is independent of and can be adjudicated without analysis or interpretation of the ERISA plan. *Amici* believe that to do so provides a solution to the issues raised in the present cases which is harmonious with the Court's prior ERISA decisions, consistent with its related jurisprudence under the LMRA, and mindful of the limits the Court has repeatedly placed on the preemption of State law.

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[11] *Cf. Danca v. Private Health Care Sys., Inc.*, 185 F.3d 1 (1st Cir. 1999); *Hull v. Fallon*,188 F.3d 939 (8th Cir. 1999); *In re U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir. 1999).

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